Additional Questions for the Record for Mr. Thomas Miller

"A 21st Century Medicare: Bipartisan Proposals to Redesign the Program's Outdated Benefit Structure"

June 26, 2013

The Honorable Gus Bilirakis

1. **One of the great challenges of health care is the issue of price transparency. Health care is one of the biggest sectors of our economy where no one knows the cost of a service. Under a co-pay system, a patient could know the cost of a medical service in advance, but that cost does not necessarily represent the total actual cost of the service. Under a co-insurance system, a patient might not know the cost of a service until after the service is performed. When designing a new benefit structure, how can we increase the level of transparency in the system so beneficiaries can know what their costs will be before they even visit the doctor?**

   Increased transparency requires both stronger demand and expanded supply. The interaction between them can propel each one forward. The role of a new benefit structure is to incentivize beneficiaries to have a greater stake in knowing the costs of the health care choices they make. Increased cost sharing that focuses on the more discretionary decisions faced by beneficiaries, but caps their maximum out-of-pocket exposure to levels that they can manage, provides the best tool to increase cost consciousness. The traditional Medicare fee-for-service program performs poorly on this front. Its initial-dollar deductibles are either too small (Part B), too irrelevant to most health care decisions (Part A) that are influenced by other factors, or too hard to adjust over time. Its coinsurance under Part B is uncapped and potentially exposes beneficiaries without supplemental insurance coverage to catastrophic financial risks.

   A new benefit structure should send clearer signals to which beneficiaries can respond more effectively. This hearing and my testimony has focused on reform of the traditional Medicare program, because the private plans under Medicare Advantage already have greater freedom to adopt a wider variety of benefits and cost sharing practices. They also are not as rigidly bound to the artificial distinctions between the categories of care financed under Part A (mostly inpatient hospital care) and under Part B (mostly outpatient care).

Hence, one leading option is to change traditional Medicare's cost sharing to feature a unified deductible for spending under both Part A and Part B; most likely at a level between the current ones for each respective program. A higher level of cost sharing at the front end of health spending decisions also can help finance the establishment of a maximum out-of-pocket "stop loss" limit for combined expenses under the inpatient and outpatient parts of the traditional Medicare program. If designed in a balanced manner, such cost sharing reform also can diminish the demand for supplemental Medigap insurance coverage that largely suppresses incentives for most beneficiaries to be cost-conscious and economize at point-of-service decision-making moments.

A different approach highlighted in my written testimony could involve a "major risk" type of cost sharing, which relies on an income-related stop-loss cap on all out-of-pocket expenses and a switch from front-end deductibles to a longer corridor of coinsurance at a higher rate than the current 20-percent rate for Part B.

Each type of cost sharing – deductibles, copayments, and coinsurance – has its own set of advantages and limitations regarding price transparency incentives. Deductibles send a full-strength signal regarding the complete cost of a service or procedure. But they tend to produce binary choices to either seek out and receive a particular treatment or pass it up completely. They are not as effective in encouraging beneficiaries to weigh the marginal benefits and costs of close substitutes or additional increments of care. Copayments tend to be denominated in relatively modest amounts, which provide little information about the full marginal costs of more discretionary health care decisions. Recent proposals to develop a wider variety of copayments for services, procedures, and other medical treatments tied to their relative "value" lack a sufficiently deep and robust evidence base to merit widespread application. Coinsurance provides a partial insurance cushion against the full cost of the services to which it applies, while maintaining incentives to consider their marginal out-of-pocket costs and overall value at the same time.

Even if we improve the incentives for traditional Medicare beneficiaries to want to know more about the cost of their care and then act upon it when they make health spending decisions, that alone will not fully solve the "supply" problem regarding accessible and actionable information. We need to build on recent progress in enhancing the availability of Medicare data about the relative costs of different services and patterns of treatment that are delivered by different health care providers. We also need to go well beyond a listing of simplistic price tags for isolated services and procedures and provide at least a range of estimated "all-in" costs for more complex episodes of care across multiple health care providers. Rules for which entities are allowed access to such data (while ensured full privacy protection for personal health information) should be liberalized, in order to foster stronger competition in producing patient-friendly information about the

relative cost and quality (i.e., the overall "value") of different health care providers and the services they offer. Building a more useful and accurate information infrastructure for value-based decision making (as determined by patients, providers, and payers) will require more trial and error through competitive channels that pay attention to end users, rather than the largely top-down, centralized approach that has repeatedly stalled or failed in the past.

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2. **Is it worthwhile to have multiple Medicare plans in the marketplace? CMS could establish an actuarial value and allow various plans of different premiums/deductibles/cost-shares. This would allow seniors to choose a plan that fits their lifestyle and health status rather than a one-size-fits-all plan.**

Medicare beneficiaries have already voted with their feet and their wallets. They very much welcome and value a wider variety of Medicare plans – both as alternatives to traditional Medicare services under Parts A & B, and as a competitive marketplace for either integrated or stand-alone prescription drug coverage under Part D. Competition and choice among Medicare plans helps match them with the diverse preferences and needs of beneficiaries. The rules for structuring this competition among private Medicare plans, as well as between them and the traditional Medicare program, have evolved and generally improved over time, after more mixed experience in earlier iterations (such as private plan options under the TEFRA rules of the 1980s and early 1990s for Medicare HMOs, the ill-fated Medicare+Choice rules under the Balanced Budget Act of 1997, and even the early, over-generous bidding benchmarks set under the Medicare Modernization Act of 2003) failed to ensure competition in cost-effectiveness. Risk adjustment has improved over the last decade, though it remains far from perfect. Finding a sustainable formula for level-playing-field competition between Medicare Advantage plans and traditional Medicare that improves the mix of cost and quality remains elusive, although better models of "premium support" could and should be considered. Establishing an actuarial value for the baseline level of taxpayer assistance under an improved system of Medicare plan competition (ideally first determined through "competitive bidding" ground rules rather than by budget-driven political calculations alone) would allow competing plans to offer different baseline-benefit mixes of comparable value. At the same time, beneficiaries should be allowed and encouraged to seek enhanced plan choices when they are willing to spend more of their own money to purchase them.

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3. **Traditional Medicare Fee for Service operates in two different silos, Part A & B, without either part talking to each other. Medicare Advantage provides a comprehensive benefit with coordination between hospital and outpatient settings. Do we have data evaluating Medicare Advantage against traditional fee-for-service? Does Medicare Advantage provide lower costs and better outcomes compared to traditional fee-for-service? What lessons from Medicare Advantage can we apply to redesigning traditioal Medicare?**

We have some limited data in published research that tells a mixed story. In general, Medicare Advantage (MA) plans -- particularly private HMO plans -- have demonstrated better health quality ratings and better outcomes compared to traditional Medicare (FFS) for a number of standard measures. The evidence regarding relative cost-effectiveness is clouded by changing payment methods over time, plus difficulty in accounting for all of the relative advantages and disadvantages within the different features of MA and FFS.

For example, a study in the February 2012 issue of the *American Journal of Managed Care* found that 30-day hospital readmission rates were 13 percent to 20 percent lower in MA plans than for traditional Medicare FFS. A peer-reviewed 2007 study in *Medical Care Research and Review* found that beneficiaries in Medicare HMOs have fewer avoidable hospitalizations than Medicare FFS beneficiaries. MA beneficiaries also are less likely to report trouble in receiving care, more likely to receive necessary preventive services, and more likely to have a usual source of care.

In comparing the costs of MA plans versus FFS, it depends on whether is measuring cost-effectiveness in delivering comparable basic benefits or evaluating total costs under different methods of reimbursement. In recent years, MedPAC analysis has found that MA plan benchmark bids for similar beneficiaries have been below those of Medicare FFS (96 percent in 2013, down from 98 percent in 2012). The most common type of MA plans --- Medicare HMOs – have performed even more efficiently; bidding 92 percent of FFS spenidng in 2013. However, additional benchmark reimbursement formulas have raised overall taxpayer spending on MA plans above that of comparable FFS rates in many market areas. MA plans have directed these additional payments primarily toward enhanced benefits, and somewhat lower cost sharing, for beneficiaries in order to increase their market share. MA advocates also point out that the somewhat higher reimbursement rates help to compensate for the longstanding advantages of FFS as an entrenched, dominant incumbent withn the Medicare program (including being the default selection for newly eligible seniors and retaining the legal authority to dictate its own administered prices to

providers). They also note that a full accounting of comparable costs should include the supplemental Medigap premiums that many FFS beneficiaries have to pay to gain access to MA-equivalent benefits.

Although some disagreement among outside analysts remains about the accuracy of risk adjustment mechanisms in ensuring apples-to-apples cost comparisions between MA and FFS, a more aggressive version of premium support financing of Medicare options on a level playing field (such as proposed by several of my AEI colleagues) would deliver larger taxpayer savings and push both MA plans and the traditional FFS program to lower their costs and improve their quality.

The most important lessons to be learned from MA are that coordinating and integrating care to treat the "whole patient" improves health outcomes and lowers costs. Having to attract and retain Medicare beneficiaries, instead of automatically enrolling them when they reach the age of eligibility, also sharpens accountability for performance in a patient-centered manner. The MA side of the Medicare program also is more open to innovation in health care treatment and health plans' adoption of successful practices implemented by their competitors. Applying these lessons to the traditional FFS program is more difficult, but not impossible; such as in better versions of current experiments with accountable care organizations, medical homes, bundled payment, and value-based reimbursement. Breaking down the arbitary payment silos that separate Part A and Part B of FFS, as well as integrating cost-sharing provisions across the continuum of care, would represent a good start.

4. **There is concern that MediGap plans driving up cost, providing less benefit for seniors, and we should think about alternatives to those plans. What if we gave everyone an HSA? Millions of Americans have an HSA today and they will age into the Medicare population. Do we have data, on average, how much seniors would have in an HSA as they entered Medicare, or could have, if HSA's were more widespread and used over a lifetime? If seniors had HSA's with a lifetime of savings in it, there would be less need for MediGap policies, and seniors would be better equipped to cover sudden health care spending spikes.**

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Wider access to HSAs, and greater use of time, can help contribute to post-retirement assets for health care needs. The size of retained balances at age 65 are sensitive to underlying assumptions about interest rates, duration of HSA-contribution eligibility, levels of contributions, and retention of HSA contributions over time as savings rather than for pre-retirement health care spending. The earliest rough model for potential net savings from tax-advantaged health accounts for active workers was provided by Eichner, McClellan, and Wise in a 1996 National Bureau of Economic Research working paper. Their study found that, within the assumed parameters of one particular individual health account model, approximately 80 percent of the employees would have retained over 50 percent of their tax-advantaged contributions by the time of retirement, and only 5 percent of the workes would have saved less than 20 percent of their contributions. The key finding was that any particular period of pre-retirement-years of high health care expenses does not persist as more and more years of health expenditures are cumulated.

A more recent analysis of likely HSA savings during pre-retirement years by the Employee Benefit Research Institute (Fronstin 2010) is more skeptical. It notes that current limits on maximum annual HSA contributions, low interest rates, and much higher post-retirement health expenses (Medicare and supplemental insurance premiums, plus other out-of-pocket expenses not covered by Medicare) indicate that retained HSA savings at the age of Medicare eligibility can make only a modest contribution (16-32 percent) to the latter. However, the EBRI study assumes only a ten-year period of HSA contributions (by a man aged 55 in 2009), primarily limits investment of contributions to low-interest savings vehicles, and predicts a substantial level of health expenses not reimbursed through Medicare (roughly half of all retiree health costs). EBRI notes that its estimates do not take into account the likely use of a share of HSA contributions for pre-retirement health care needs, plus the higher retiree health expenses faced by women (with longer average life expectancy).

The best way to view this issue is to see HSAs as a valuable contributor to increased savings for post-retiree health care needs, but not sufficient alone to fill a very large

future resource gap between expectations and personal assets. Although HSA funds cannot be used directly to pay for Medigap premiums, they can be withdrawn tax-free to pay other retiree health premiums (for Medicare Part B or Part D, for MA plans, or for employers' supplemental retiree coverage), as well as eligible out-of-pocket health expenses. Moreover, cash is fungible and assets available to handle out-of-pocket healht expenses for Medicare retirees can reduce the demand, and need, for supplemental Medigap coverage.

The most recent figures for HSA balances indicate that they continue to grow (up 24 percent from 2011 to 2012, and projected to reach $26.9 billion by 2015, according to two surveys by AHIP and Devinir Research, respectively). However, more than halfof current accounts have less than $1000. The oldest accounts tabulated – those opened in 2005 – have an average balance of $4,668. On a more promising note, the average account balance in HSAs has grown from $1476 in December 2009 to $2283 in December 2012. From December 2011 to December 2012, about 23 percent of total contributions made to HSAs were retained.